

STATE OF WYOMING
WORKERS' SAFETY & COMPENSATION DIVISION
CLAIM FOR PHARMACY / MEDICAL SUPPLIES
307-777-7441

PLEASE PRINT OR TYPE IN BLACK INK

Injured Worker Information

▶ **CASE #** _____

SSN # _____ Date of Birth _____

DATE OF INJURY _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Payee Information

FEDERAL TAX ID# _____
OR SSN# _____ Required for payment

PAYEE NAME _____

**ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # () _____ — _____

INVOICE / PATIENT # _____

NABP# / NCPDP# _____

NOTE: Do not use abbreviations or symbols for drugs or supplies. Itemize supplies dispensed. Provide name of prescribing physician. Payments for drugs will be based upon *the Redbook* average wholesale price plus dispensing fee per prescription item. Reference Division Rules, Chapter 9 and 10.

Date Dispensed	National Drug Code	Qty.	TOTAL CHARGES	Invoice or RX #	Doctor's Name	Days Supply
	Name of Drug or Item			DAW Code / Refill	DEA #	

** Pharmacy Name & Location REQUIRED, if different than Payee Name:

TOTAL:

For Division Use Only

I hereby certify under penalty of perjury, that all items billed above were rendered solely on account of the original compensable injury and are true, accurate and complete to the best of my knowledge.

▶ _____
Payee's Signature (required) **Date**

INSTRUCTIONS FOR FILING: Submit billing no later than the 30th of each month for prior month's services or CLAIM MAY BE DENIED

MAIL ORIGINAL TO: Wyoming Workers' Safety & Compensation Division
PO Box 20070
Cheyenne, WY 82003-7001